



MASSACHUSETTS

## SUMMARY OF BENEFITS



# Network Blue Options<sup>SM</sup> v.5



This health plan includes a tiered provider network called HMO Blue Options v.5. Members in this plan pay different levels of cost share (copayments, coinsurance, and/or deductibles) depending on the benefits tier of the provider furnishing the services. A provider's benefits tier may change. Overall changes to the benefits tiers of providers will happen no more than once each calendar year. For help in finding the benefits tier of a provider, visit the online provider search tool at [www.bluecrossma.com/findadoctor](http://www.bluecrossma.com/findadoctor) and search for HMO Blue Options v.5.



This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect January 1, 2014, as part of the Massachusetts Health Care Reform Law.

# Your Care

Within the HMO Blue Options v.5 network, hospitals and groups of primary care providers (PCPs) are ranked into three benefits tiers based on cost and nationally accepted quality performance criteria selected by Blue Cross Blue Shield of Massachusetts.

**Where you receive care will determine your out-of-pocket costs for most services under the plan.** By choosing Enhanced Benefits Tier providers each time you get hospital or PCP care, you can generally lower your out-of-pocket costs.

- **Enhanced Benefits Tier**—Includes Massachusetts hospitals and PCPs that meet the standards for quality and low cost relative to our benchmark. You pay the lowest out-of-pocket costs when you choose providers in the Enhanced Benefits Tier.
- **Standard Benefits Tier**—Includes Massachusetts hospitals and PCPs that meet the standards for quality and are moderate cost relative to our benchmark. This benefit tier includes hospitals that do not meet the standards for quality but are low or moderate cost relative to our benchmark. You pay mid-level out-of-pocket costs when you choose providers in the Standard Benefits Tier. Also includes providers without sufficient data for measurement on one or both benchmarks. To ensure members have provider access in certain geographic areas, the Standard Benefits Tier includes some providers whose scores would otherwise put them in the Basic Benefits Tier.
- **Basic Benefits Tier**—Includes Massachusetts hospitals that are high cost relative to our benchmark. Also includes primary care providers in Massachusetts who do not meet the standards for quality and/or are high cost relative to our benchmark. You pay the highest out-of-pocket costs when you choose providers in the Basic Benefits Tier.

Note: Primary care providers were measured based on their HMO patients as part of their provider group, and hospitals were measured based on their individual facility performance. Provider groups can be composed of an individual provider, or a number of providers who practice together. Tier placement is based on cost and quality benchmarks where measurable data is available. Providers without sufficient data for either cost or quality are placed in the Standard Benefits Tier. Providers that do not meet benchmarks for one or both of the domains and hospitals that use nonstandard reimbursement are placed in the Basic Benefits Tier.

It is important to consider the tier of both your primary care provider and the facility where your provider has admitting privileges before you choose a PCP or receive care. For example, if you require hospital care and your Enhanced Benefits Tier PCP refers you to an Enhanced Benefits Tier hospital, you would pay the lowest cost sharing for both your PCP and hospital services. Or, if your Enhanced Benefits Tier PCP refers you to a Basic Benefits Tier hospital for care, you will pay the lowest copayments for PCP services, but the highest copayments for hospital services, except in an emergency.

## Your Primary Care Provider (PCP)

When you enroll in Network Blue, you must choose a primary care provider. Be sure to choose a PCP who can accept you and your family members and who participates in the network of providers in Massachusetts. For children, you may choose a participating network pediatrician as the PCP.

For a list of participating PCPs or OB/GYN physicians; visit the Blue Cross Blue Shield of Massachusetts website at [www.bluecrossma.com](http://www.bluecrossma.com); consult the Provider Directory; or call the Physician Selection Service at 1-800-821-1388.

If you have trouble choosing a doctor, the Physician Selection Service can help. They can give you the doctor's gender, the medical school she or he attended, and whether there are languages other than English spoken in the office.

## Referrals You Can Feel Better About

Your PCP is the first person you call when you need routine or sick care. If your PCP decides that you need to see a specialist for covered services, your PCP will refer you to an appropriate network specialist, who is likely affiliated with your PCP's hospital or medical group.

You will not need prior authorization or referral to see a HMO Blue network provider who specializes in OB/GYN services. Your providers may also work with Blue Cross Blue Shield of Massachusetts regarding referrals and Utilization Review Requirements, including Pre-Admission Review, Concurrent Review and Discharge Planning, Prior Approval for Certain Outpatient Services, and Individual Case Management. For detailed information about Utilization Review, see your benefit description.

## Your Out-of-Pocket Maximum

Your out-of-pocket maximum is the most that you could pay during a plan year for copayments and coinsurance for covered services. If you are not sure when your plan year begins, please contact Blue Cross Blue Shield of Massachusetts. Your out-of-pocket maximum for medical benefits is **\$2,500** per member (or **\$5,000** per family). Your out-of-pocket maximum for prescription drug benefits is **\$1,000** per member (or **\$2,000** per family).

## Emergency Care

In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call 911 (or the local emergency phone number). You pay a copayment per visit for emergency room services. This copayment is waived if you are admitted to the hospital or for an observation stay. See the chart on the opposite page for your cost share. Additionally, because you may not have a choice during an emergency, if you are admitted for an inpatient stay from the emergency room, you will be responsible for an Enhanced Benefits Tier copayment regardless of the tier of the hospital. Any follow-up care must be arranged by your PCP.

## Service Area

The plan's service area includes all cities and towns in the Commonwealth of Massachusetts. See your benefit description for exact service area details.

## When Outside the Service Area

If you're traveling outside the service area and you need urgent or emergency care, you should go to the nearest appropriate health care facility. You are covered for the urgent or emergency care visit and one follow-up visit while outside the service area. Any additional follow-up care must be arranged by your PCP. See your benefit description for more information.

## Dependent Benefits

This plan covers dependents until the end of the calendar month in which they turn age 26, regardless of their financial dependency, student status, or employment status. See your benefit description (and riders, if any) for exact coverage details.

# Your Medical Benefits

Covered Services	Your Cost for Enhanced Benefits Tier Network Providers	Your Cost for Standard Benefits Tier Network Providers	Your Cost for Basic Benefits Tier Network Providers
<b>Preventive Care</b>			
Well-child care visits	Nothing	Nothing	Nothing
Preventive dental care for children under age 12 (one visit each six months)	Nothing	Nothing	Nothing
Routine adult physical exams, including related tests	Nothing	Nothing	Nothing
Routine GYN exams, including related lab tests (one per calendar year)	Nothing	Nothing	Nothing
Routine vision exam (one per calendar year)	Nothing	Nothing	Nothing
Family planning services—office visits	Nothing	Nothing	Nothing
<b>Hearing Benefits</b>			
Routine hearing exams	Nothing	Nothing	Nothing
Hearing aids (up to \$5,000 per ear every 36 months)	All charges beyond the benefit maximum	All charges beyond the benefit maximum	All charges beyond the benefit maximum
<b>Outpatient Care</b>			
Emergency room visits	\$100 per visit (waived if admitted or for observation stay)	\$100 per visit (waived if admitted or for observation stay)	\$100 per visit (waived if admitted or for observation stay)
Office visits, when performed by:			
• Your PCP, network nurse practitioner, or nurse midwife (billed by PCP)	\$10 per visit	\$15 per visit	\$20 per visit
• Network nurse practitioner or nurse midwife (not billed by PCP)	\$15 per visit	\$15 per visit	\$15 per visit
• Other network providers	\$25 per visit	\$25 per visit	\$25 per visit
Mental health and substance abuse treatment	\$10 per visit	\$10 per visit	\$10 per visit
Chiropractors' office visits (up to 20 visits per calendar year)	\$15 per visit	\$15 per visit	\$15 per visit
Short-term rehabilitation therapy—physical, and occupational (up to 90 visits per calendar year*)	\$15 per visit	\$15 per visit	\$15 per visit
Speech, hearing, and language disorder treatment—speech therapy	\$15 per visit	\$15 per visit	\$15 per visit
Home health care and hospice services	Nothing	Nothing	Nothing
Oxygen and equipment for its administration	Nothing	Nothing	Nothing
Prosthetic devices	20% coinsurance	20% coinsurance	20% coinsurance
Durable medical equipment—such as wheelchairs, crutches, and hospital beds	Nothing	Nothing	Nothing
Surgery and related anesthesia, when performed in:			
• An office setting: PCP/Other network providers	\$10 per visit**/\$25 per visit**	\$15 per visit**/\$25 per visit**	\$20 per visit**/\$25 per visit**
• Hospital and other day surgical facility services	\$150 per admission	\$150 per admission	\$150 per admission
Diagnostic X-rays, lab tests, and other tests, excluding CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	Nothing	Nothing	Nothing
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	\$100 per category of test per date of service	\$100 per category of test per date of service	\$100 per category of test per date of service
<b>Inpatient Care (and maternity care)</b>			
General hospital care (as many days as medically necessary)	\$200 per admission	\$400 per admission***	\$400 per admission***
Chronic disease hospital care (as many days as medically necessary)	\$200 per admission	\$200 per admission	\$200 per admission
Mental hospital or substance abuse facility care (as many days as medically necessary)	\$200 per admission	\$200 per admission	\$200 per admission
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing	Nothing	Nothing
Skilled nursing facility care (up to 45 days per calendar year)	Nothing	Nothing	Nothing

\* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders.

\*\* Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.

\*\*\* This cost share applies to mental health admissions in a general hospital.

<b>Prescription Drug Benefits*</b>	<b>Your Cost for Enhanced Benefits Tier Network Providers**</b>	<b>Your Cost for Standard Benefits Tier Network Providers**</b>	<b>Your Cost for Basic Benefits Tier Network Providers**</b>
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	\$10 for Tier 1*** \$25 for Tier 2 \$50 for Tier 3	\$10 for Tier 1*** \$25 for Tier 2 \$50 for Tier 3	\$10 for Tier 1*** \$25 for Tier 2 \$50 for Tier 3
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	\$20 for Tier 1*** \$50 for Tier 2 \$110 for Tier 3	\$20 for Tier 1*** \$50 for Tier 2 \$110 for Tier 3	\$20 for Tier 1*** \$50 for Tier 2 \$110 for Tier 3

\* Tier 1 generally refers to generic drugs; Tier 2 generally refers to preferred brand-name drugs; Tier 3 refers to non-preferred drugs.

\*\* Cost share waived for certain orally-administered anticancer drugs.

\*\*\* Cost share waived for birth control.

## Get the Most from Your Plan

Visit us at [www.bluecrossma.com/membercentral](http://www.bluecrossma.com/membercentral) or call 1-800-782-3675 to learn about discounts, savings, resources, and special programs available to you, like those listed below.

<b>Wellness Participation Program</b>	
<b>Reimbursement for a membership at a health club or for fitness classes</b> This fitness program applies for fees paid to: privately-owned or privately-sponsored health clubs or fitness facilities, including individual health clubs and fitness centers; YMCAs; YWCAs; Jewish Community Centers; and municipal fitness centers. (See your benefit description for details.)	\$150 per calendar year per policy
<b>Reimbursement for participation in a qualified weight loss program</b> This weight loss program applies for fees paid to: a qualified hospital-based weight loss program or a Blue Cross Blue Shield of Massachusetts designated weight loss program. (See your benefit description for details.)	\$150 per calendar year per policy
Blue Care Line <sup>SM</sup> —A 24-hour nurse line to answer your health care questions—call 1-888-247-BLUE (2583)	No additional charge

## Questions?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-782-3675, or visit us online at [www.bluecrossma.com](http://www.bluecrossma.com).

Interested in receiving information from us via e-mail? Go to [www.bluecrossma.com/email](http://www.bluecrossma.com/email) to sign up.

**Limitations and Exclusions.** These pages summarize the benefits of your health care plan. Your benefit description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the benefit description and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your benefit description and riders.

**Note:** Blue Cross and Blue Shield of Massachusetts, Inc. administers claims payment only and does not assume financial risk for claims.





## Network Blue Options v.5

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: on or after 07/01/2016

Coverage for: Individual and Family | Plan Type: Managed Tiered



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at <http://www.emia.org/health-and-dental-insurance> or by calling **1-800-782-3675**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. For medical benefits, <b>\$2,500</b> member / <b>\$5,000</b> family; and for prescription drug benefits, <b>\$1,000</b> member / <b>\$2,000</b> family.	The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
Does this plan use a <b>network of providers</b> ?	Yes. See <a href="http://www.bluecrossma.com/findadoctor">www.bluecrossma.com/findadoctor</a> or call 1-800-821-1388 for a list of network providers.	If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
Do I need a referral to see a <b>specialist</b> ?	Yes.	This plan will pay some or all of the costs to see a <b>specialist</b> for covered services but only if you have the plan's permission before you see the <b>specialist</b> .
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about <b>excluded services</b> .

Questions: Call 1-800-782-3675 or visit us at [www.bluecrossma.com](http://www.bluecrossma.com).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.bluecrossma.com/sbcglossary](http://www.bluecrossma.com/sbcglossary) or call 1-800-782-3675 to request a copy.

Blue Cross Blue Shield of Massachusetts is an independent licensee of the Blue Cross and Blue Shield Association



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** (or provider's charge if it is less than the **allowed amount**) for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000 (and it is less than the provider's charge), your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network enhanced benefits tier **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts. (If you are eligible to elect a Health Reimbursement Account (HRA), Flexible Spending Account (FSA) or you have elected a Health Savings Account (HSA), you may have access to additional funds to help cover certain **out-of-pocket** expenses such as **copayments**, **coinsurance**, **deductibles** and costs related to services not otherwise covered.)

Common Medical Event	Services You May Need	Your cost if you use				Limitations & Exceptions
		Enhanced Benefits Tier	Standard Benefits Tier	Basic Benefits Tier	Out-of-Network	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$10 / visit	\$15 / visit	\$20 / visit	Not covered	--- none ---
	Specialist visit	\$25 / visit	\$25 / visit	\$25 / visit	Not covered	--- none ---
	Other practitioner office visit	\$15 / chiropractor visit	\$15 / chiropractor visit	\$15 / chiropractor visit	Not covered	Limited to 20 visits per calendar year
	Preventive care/screening/immunization	No charge	No charge	No charge	Not covered	GYN exam limited to one exam per calendar year
If you have a test	Diagnostic test (x-ray, blood work)	No charge	No charge	No charge	Not covered	--- none ---
	Imaging (CT/PET scans, MRIs)	\$100	\$100	\$100	Not covered	Copayment applies per category of test / day; pre-authorization required for certain services

Common Medical Event	Services You May Need	Your cost if you use				Limitations & Exceptions
		Enhanced Benefits Tier	Standard Benefits Tier	Basic Benefits Tier	Out-of-Network	
<b>If you need drugs to treat your illness or condition</b>  More information about <b>prescription drug coverage</b> is available at <a href="http://www.bluecrossma.com/medications">www.bluecrossma.com/medications</a>	Generic drugs	\$10 / retail supply or \$20 / mail service supply	\$10 / retail supply or \$20 / mail service supply	\$10 / retail supply or \$20 / mail service supply	Not covered	Up to 30-day retail (90-day mail service) supply; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs
	Preferred brand drugs	\$25 / retail supply or \$50 / mail service supply	\$25 / retail supply or \$50 / mail service supply	\$25 / retail supply or \$50 / mail service supply	Not covered	Up to 30-day retail (90-day mail service) supply; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs
	Non-preferred brand drugs	\$50 / retail supply or \$110 / mail service supply	\$50 / retail supply or \$110 / mail service supply	\$50 / retail supply or \$110 / mail service supply	Not covered	Up to 30-day retail (90-day mail service) supply; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs
	Specialty drugs	Applicable cost share (generic, preferred, non-preferred)	Applicable cost share (generic, preferred, non-preferred)	Applicable cost share (generic, preferred, non-preferred)	Not covered	When obtained from a designated specialty pharmacy; pre-authorization required for certain drugs
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$150 / admission	\$150 / admission	\$150 / admission	Not covered	Pre-authorization required for certain services
	Physician/surgeon fees	No charge	No charge	No charge	Not covered	Pre-authorization required for certain services
<b>If you need immediate medical attention</b>	Emergency room services	\$100 / visit	\$100 / visit	\$100 / visit	\$100 / visit	Copayment waived if admitted or for observation stay
	Emergency medical transportation	No charge	No charge	No charge	No charge	--- none ---
	Urgent care	\$25 / visit	\$25 / visit	\$25 / visit	\$25 / visit	Out-of-network coverage limited to out of service area

Common Medical Event	Services You May Need	Your cost if you use				Limitations & Exceptions
		Enhanced Benefits Tier	Standard Benefits Tier	Basic Benefits Tier	Out-of-Network	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$200 / admission	\$400 / admission	\$400 / admission	Not covered	Pre-authorization required
	Physician/surgeon fee	No charge	No charge	No charge	Not covered	Pre-authorization required
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$10 / visit	\$10 / visit	\$10 / visit	Not covered	Pre-authorization required for certain services
	Mental/Behavioral health inpatient services	\$200 / admission for mental hospitals or substance abuse facilities; \$200 / admission for hospitals	\$200 / admission for mental hospitals or substance abuse facilities; \$400 / admission for general hospitals	\$200 / admission for mental hospitals or substance abuse facilities; \$400 / admission for general hospitals	Not covered	Pre-authorization required
	Substance use disorder outpatient services	\$10 / visit	\$10 / visit	\$10 / visit	Not covered	Pre-authorization required for certain services
	Substance use disorder inpatient services	\$200 / admission for mental hospitals or substance abuse facilities; \$200 / admission for general hospitals	\$200 / admission for mental hospitals or substance abuse facilities; \$400 / admission for general hospitals	\$200 / admission for mental hospitals or substance abuse facilities; \$400 / admission for general hospitals	Not covered	Pre-authorization required for certain services



Common Medical Event	Services You May Need	Your cost if you use				Limitations & Exceptions
		Enhanced Benefits Tier	Standard Benefits Tier	Basic Benefits Tier	Out-of-Network	
If you are pregnant	Prenatal and postnatal care	No charge	No charge	No charge	Not covered	--- none ---
	Delivery and all inpatient services	\$200 / admission and no charge for delivery	\$400 / admission and no charge for delivery	\$400 / admission and no charge for delivery	Not covered	--- none ---
If you need help recovering or have other special health needs	Home health care	No charge	No charge	No charge	Not covered	Pre-authorization required
	Rehabilitation services	\$15 / visit	\$15 / visit	\$15 / visit	Not covered	Limited to 90 visits per calendar year (other than for autism, home health care, and speech therapy); pre-authorization required for certain services
	Habilitation services	\$15 / visit	\$15 / visit	\$15 / visit	Not covered	Rehabilitation therapy coverage limits apply; cost share and coverage limits waived for early intervention services for eligible children; pre-authorization required for certain services
	Skilled nursing care	No charge	No charge	No charge	Not covered	Limited to 45 days per calendar year; pre-authorization required
	Durable medical equipment	No charge	No charge	No charge	Not covered	-- none --
	Hospice service	No charge	No charge	No charge	Not covered	Pre-authorization required for certain services
If your child needs dental or eye care	Eye exam	No charge	No charge	No charge	Not covered	Limited to one exam per calendar year
	Glasses	Not covered	Not covered	Not covered	Not covered	--- none ---
	Dental check-up	No charge	No charge	No charge	Not covered	Limited to children under age 12 (every 6 months) and under age 18 with a cleft palate / cleft lip condition

## Excluded Services & Other Covered Services:

### Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Children's glasses
- Cosmetic surgery
- Dental care (adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

### Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care (20 visits per calendar year)
- Hearing aids (\$5,000 per ear every 36 months)
- Infertility treatment
- Routine eye care - adult (one exam per calendar year)
- Routine foot care (only for patients with systemic circulatory disease)
- Weight loss programs (\$150 per calendar year per policy)

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact your plan sponsor. Note: A plan sponsor is usually the member's employer or organization that provides group health coverage to the member. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa) or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cms.gov](http://www.cms.gov).

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Member Service number listed on your ID card or contact your plan sponsor. Note: A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Assistance

To obtain language assistance, please call the toll-free Member Service number on your ID card.

**SPANISH (Español):** Para obtener asistencia en español, llame al número gratuito de Servicio de Atención al Miembro que figura en su tarjeta de identificación.

**TAGALOG (Tagalog):** Kung kailangan ninyo ng tulong sa Tagalog tumawag sa libreng numero ng telepono ng Serbisyo sa Miyembro na nakasulat sa inyong ID card.

**CHINESE (中文):** 如果您需要中文語言幫助，請撥打會員卡上的客戶服務免費電話號碼

**NAVAJO (Dine):** Dine'ehjí shika' a'dowol ninizingo, kwoji hodiitné t'áá jííkeh béesh bee' hane'ji T'áá doolé'é bina'ishdiikidgo yeeháka'adooljah éí binumber bee néého'dolzin biniiyé naanitinígí bikáá' doo.

## Disclaimer:

This document contains only a partial description of the benefits, limitations, exclusions and other provisions of this health care plan. It is not a policy. It is a general overview only. It does not provide all the details of this coverage, including benefits, exclusions and policy limitations. In the event there are discrepancies between this document and the policy, the terms and conditions of the policy will govern.

-----To see examples of how this plan might cover costs for a sample medical situation, see the next page.-----

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is  
not a cost  
estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$6,970
- Patient pays \$570

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$0
Copays	\$420
Coinsurance	\$0
Limits or exclusions	\$150
<b>Total</b>	<b>\$570</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,220
- Patient pays \$1,180

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$0
Copays	\$1,100
Coinsurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$1,180</b>

## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from standard benefits tier providers. If the patient had received care from other in-network or out-of-network providers, costs would have been different.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

- ✗ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

- ✗ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

- ✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

- ✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

**Questions:** Call 1-800-782-3675 or visit us at [www.bluecrossma.com](http://www.bluecrossma.com).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.bluecrossma.com/sbcglossary](http://www.bluecrossma.com/sbcglossary) or call 1-800-782-3675 to request a copy.

© Registered Marks of the Blue Cross and Blue Shield Association © 2016 Blue Cross and Blue Shield of Massachusetts, Inc., and Blue Cross and Blue Shield of Massachusetts 1823 Blue, Inc.

1562397

16173-06



MASSACHUSETTS

## MCC Compliance

- ✓ This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect as of January 1, 2014, as part of the Massachusetts Health Care Reform Law.



MASSACHUSETTS

## Information About the Plan

This health plan includes a tiered provider network called HMO Blue Options v.5. Members in this plan pay different levels of cost share (copayments, co-insurance, and/or deductibles) depending on the benefits tier of the provider furnishing the services. A provider's benefits tier may change. Overall changes to the benefits tiers of providers will happen no more than once each calendar year. For help in finding the benefits tier of a provider, visit the online provider search tool at [www.bluecrossma.com/findadoctor](http://www.bluecrossma.com/findadoctor) and search for HMO Blue Options v.5.